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Detainee Health Care: Essential Element of Stability Operations

by

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DETAINEE HEALTH CARE: ESSENTIAL ELEMENT OF STABILITY OPERATIONS

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ABSTRACT

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DETAINEE HEALTH CARE: ESSENTIAL ELEMENT OF STABILITY OPERATIONS

> We will continue to rebalance our military capabilities to excel at counterterrorism, counterinsurgency, stability operations, and meeting increasingly sophisticated security threats, while ensuring our force is ready to address the full range of military operations. The United States and the international community cannot shy away from the difficult tasks of pursuing stabilization in conflict and post-conflict environments. In countries like Iraq and Afghanistan, building the capacity for security, economic growth, and good governance is the only path to long term peace and security.
>
> —President Barack Obama[1]

The United States involvement in stability operations stretches over 200 years.[2] Despite this long history of stability operations, the U.S. Army and the Department of Defense (DoD) did not designate stability operation tasks as a core mission until 2005. Stability operations play an essential role in shaping the strategic environment, winning wars, and securing the peace. Stability operations are now recognized as more important to the lasting success of military operations than traditional combat operations.[3]

In May 2010, Department of Defense Instruction 6000.16 established policy, assigned responsibility, and provided instruction for military health support of stability operations. Accordingly Medical Stability Operations (MSO) was designated a core DoD Military Health System (MHS) mission. The MHS must prepare to conduct MSO throughout all phases of conflict, across a range of military operations, to include combat and non-combat environments. As with combat operations, MSO's doctrine, organization, training, education, exercises, material, leadership, personnel, facilities, and planning are integrated into the MHS's role in Stability Operations.[4]

Officially established as an essential component of stability operations in 2010, MSOs have been an essential element of Stability Operations throughout U.S. history. A

Rand report examined public health and health care delivery during nation-building and stability operations in Germany and Japan after World War II and in Somalia, Haiti, Kosovo, and current operations in Iraq and Afghanistan. The report concluded that delivery of medical care was an essential component of building stable democratic governments after conflicts.[5]

In response to the lack of coordination among government agencies during contingency operations in Somalia, Haiti, and Bosnia, President Clinton issued Presidential Decision Directive (PPD) 56, Managing Complex Contingency Operations. Although PPD 56 addressed the need to reform stability and reconstruction operations (SRO), internal bureaucratic resistance prevented effective implementation of PPD 56. The wars in Iraq and Afghanistan have prompted further efforts to improve SRO planning, management, and oversight.[6]

National Security Presidential Directive (NSPD) 24, published in January 2003, assigned DoD exclusive responsibility for reconstructing post-war Iraq. In response DoD created the Office of Reconstruction and Humanitarian Assistance (ORHA). ORHA tasked the military and the Coalition Provisional Authority (CPA) to plan, oversee, and execute relief and reconstruction efforts in Iraq.[7] Within six weeks of the invasion of Iraq, NSPD-36 superseded NSPD-24; SRO responsibilities were transferred to the Department of State (DOS). Accordingly, DOS created the Office of the Coordinator for Reconstruction and Stabilization (S/CRS).[8] The S/SRC was combined with the Bureau of Conflict and Stabilization Operations in December 2011.[9]

In December 2005 NSPD-44 superseded NSPD-36. Significantly, NSPD-44 attempts to establish national policy for interagency integration focused on SRO.[10]

NSPD-44 assigns DOS as the lead agency for coordinating among U. S. government agencies to prepare and conduct stability operations.[11] DoD implemented Department of Defense Directive (DoDD) 3000.05 in November 2005. DoDD 3000.05 reissued in 2009 reiterates guidance to military forces on the conduct of stability operations. Also it establishes these operations as a core military mission, equal in priority to combat operations.

> Stability operations are a core U.S. military mission that the Department of Defense shall be prepared to conduct with proficiency equivalent to combat operations. The Department of Defense (DoD) shall be prepared to conduct stability operations activities throughout all phases of conflict and across the range of military operations, including in combat and non-combat environment. All DoD Components shall explicitly address and integrate stability operations-related concepts and capabilities across doctrine, organization, training, material, leadership and education, personnel, facilities, and applicable exercises, strategies and plans.[12]

Accordingly, U.S. forces assume responsibility for stability operation in the event civilian agencies are not prepared to perform the tasks. The likelihood of stability operations is very high because of the tenuous nature and fragility of failing or failed states.[13] A growing trend in the post-Cold War security environment is the requirement to conduct stability operations in conflict-prone regions. In fact, every two years since 1989 the U.S. has undertaken a new stability operation.[14]

Secretary of Defense (Ret) Robert Gates' 2008 National Defense Strategy (NDS) emphasized the importance of strong and stable partners in the war on terror:

> The use of force plays a role, yet military efforts to capture or kill terrorists are likely to be subordinate to measures to promote local participation in government and economic programs to spur development, as well as effort to understand and address grievances that often lay at the heart of insurgencies. For these reasons, arguably the most important military component of the struggle against violent extremists is not the fighting we do ourselves, but how well we help prepare our partners to defend and govern themselves.[15]

In a speech to the Association of the United States Army (AUSA), Secretary Gates described future war as asymmetric conflicts that are similar to current operations in Iraq and Afghanistan.[16] "The achievement of military objectives in such conflict is less a matter of imposing one's will and more a function of shaping the behavior of friends, adversaries and most-importantly-the people in between."[17] Interagency stability operations support Secretary Gates' objective of shaping behaviors through maintaining or reestablishing a safe and secure environment; facilitating reconciliation with adversaries; establishing or rebuilding political, legal, social, and economic institutions to transition these responsibilities to a legitimate civil authority.[18] Because the greatest threat to U.S. national security comes from nations unable or unwilling to provide basic needs to their people the Army must restructure its training, its personnel policies, and its basic strategy to conduct stability operations in areas where unconventional war is being implemented.[19]

Failure to provide a safe and secure environment set the conditions for a return to fighting among warring factions in Iraq. The ensuring violent insurgency posed a significant threat to the safety and security of the local population.[20] Among the plethora of factors, which eventually led to the Iraq insurgency, the inability to stabilize the state and secure the populace was a contributing factor in the resurgence of violence. Efforts to quell the violence inevitably led to the detention of thousands of enemy combatants.[21] United States classification of these enemy combatants as detainees granted them their international legal rights under the Geneva Conventions.

Geneva Conventions

A Swiss banker, Henry J. Dunant horrified by the abandoned and untended wounded, the lack of medical supplies, and doctors he witnessed at the 1859 battle of

Solferino, established the Geneva Conventions. In “A Memory of Solferino,” Dunant appealed for volunteers to form a relief society to care for the wounded on the battlefield. His work resulted in the first Geneva Conventions in 1864, “The Convention for the Amelioration of the Condition of the Wounded.”[22]

The U.S. invasion of Iraq on 19 March 2003 opened a Common Article 2 conflict between two parties of the 1949 Geneva Conventions. A signee of the third Geneva Convention, the Geneva Convention Relative to the Treatment of Prisoners of War, the United States is bound by international law to attend to sick and wounded enemy combatants.[23] With the announcement of the end of combat operations on 1 May 2003, the United States became an occupying force. The Interim Iraqi Government was established on 28 June 2004.

The persistent violent conflict in Iraq then became one between the Government of Iraq and Al Qaeda insurgents operating within Iraq’s borders. Under these circumstances, the Iraq war became a Common Article 3 conflict under the Geneva Conventions. This Article 3 applies only to “internal” armed conflict and fighting within the borders of one country when the government’s opponents are not combatants of another country’s armed forces. Examples of armed conflicts that fall under Common Article 3 include civil wars, insurgencies, and insurrections. No other stipulations of the 1949 Geneva Convention apply in a Common Article 3 conflict, including prisoner-of-war protections. However, Article 3 does address minimal humanitarian protections for victims of war within borders of a sovereign nation. This was the first time the Geneva conventions focused on what happened within a state, not just between states.[24] On 7 July 2006, a memorandum from the Office of the Secretary of Defense confirmed that

Common Article 3 applies as a matter of law to the conflict with al Qaeda in Iraq. Accordingly, U.S. forces complied with the standards as instructed.[25]

Two protocols were added to the 1949 Geneva Conventions in 1977. An addition to Article 1 grants POW status to all combatants, regardless if they meet the four requirements of a lawful belligerent as outlined in Article 4.A(2). These four requirements include (1) command by a person responsible for subordinates, (2) distinctive uniform sign or color recognizable at a distance, (3) carrying arms openly, and (4) conducting operations in accordance with the laws and customs of war. The U.S. Senate did not ratify this portion of Additional Protocol 1. The U.S. senate has deemed it unacceptable.[26]

Classification of Enemy Combatants

The horrendous 9/11 attacks and U.S. retaliatory invasion of Afghanistan and subsequent detention of enemy combatants initiated a debate on the applicability of international treaties and laws to al Qaeda and Taliban fighters. The Department of Justice and Office of Legal Counsel advised the DoD General Counsel and the Counsel to the President that the Federal War Crimes Act and Geneva Conventions did not apply to al Qaeda and Taliban combatants. Secretary of State Colin Powell requested that the President reconsider this decision because it jeopardized adversaries' adherence to the Geneva Convention Relative to the Treatment of Prisoners of War, which grants protections to U.S. Soldiers. United States denial of these protections would undermine international compliance with laws of war.[27] Ultimately, the Secretary of State, National Security Council, Chair of the Joint Chiefs of Staff, and the President agreed that detainees would receive humane-treatment in a manner consistent with the

principles of the Geneva Conventions. However, they would not receive prisoner of war (POW) status.[28]

Treatment of Prisoners of War/Detainees

Throughout American history from the Revolution to the wars in southwest Asia and the Middle East, treatment of POWs varied widely from humane to abusive.[29] During the Civil War, The Lieber Code became General Orders 100. The foundation of the first Rule of Land Warfare, the Libber Code includes guidelines for the treatment of prisoners of war:[30]

> A prisoner of war is subject to no punishment for being a public enemy, nor is any revenge wreaked upon him by the intentional infliction of any suffering, or disgrace, by cruel imprisonment, wants of food, by mutilation, death, or any other barbarity. [31]

Missing from the 1864 and 1906 Geneva Conventions were guidelines for the treatment of able-bodied prisoners. At the 1912 International Committee for the Red Cross, the groundwork was laid to improve conditions for all POWs. This decision is one of the most important since the establishment of the Geneva Conventions in 1864. At the beginning of World War I in 1914, the International Committee of the Red Cross (ICRC) and Red Cross National Committee were ill-prepared to care for the millions of causalities and POWs. Widespread mistreatment of POWs confirmed the need for comprehensive rules for their protection. Article 97, “Convention Relative to the Treatment of Prisoners of War” addressed the issue. It was adopted on 27 July 1929.[32] This new Article affirmed the Geneva Convention’s goals to protect human rights and prevent unnecessary suffering.[33]

Although the United States has dealt with prisoners of war since the Revolutionary War, the leadership persistently failed to plan for the number of captured

or surrendered adversaries. Resources allocated for care and treatment of prisoners are rarely sufficient to accomplish an adequate job. Casual neglect ensues and military leaders struggle to deal with what becomes a distraction from their military activities.[34] U.S. military detainee operations remains based on release or repatriation of captives. Another detention option allowed U.S. authorities to turn prisoners over to another entity, organization, or host nation authority. Since the Korean War, this became the preferred United States method.[35]

During the Korean War, the South Koreans retained authority over prisoners.[36] In Vietnam, POWs were turned over to the government of South Vietnam for internment by the Army of the Republic of Vietnam (ARVN).[37] During Desert Storm, the United States and coalition forces processed more than 69, 822 POWs; Saudi Arabia took charge of their detention and repatriation.[38] The International Committee of the Red Cross (ICRC) praised U.S. treatment of Iraqi prisoners of war (POWs) during Desert Storm as the fullest compliance with the Geneva Conventions by any nation in any conflict in history.[39] Even so, numerous contributing factors set the conditions for the abuse of detainees at Abu Ghraib. Lessons learned from Operation Enduring Freedom (OEF) and early phases of Operation Iraqi Freedom (OIF) were available; they may have been helpful in tailoring doctrine for handling detainees following major combat operations in Iraq.[40]

During North Atlantic Treaty Organization (NATO) operations in the Balkans, the word “detainee” became the common term for prisoners. Operating under an International Mandate in Kosovo, the United States was not at war, so technically their captives were not POWs. Operational commanders had authority to retain or detain

individuals to ensure a “safe” and “secure” environment. A combined effort among military police, military intelligence, staff judge advocates, and tactical commanders determined detainee status. This process was adopted in OIF and OEF detention operations.[41]

U.S. improvisational POW policies led to a dramatic decline in treatment of prisoners following the initial phase of OIF. During the initial phase of OIF, there existed few locations in Iraq to protect detainees from hostile fire. No nation in the region offered to house Iraqi prisoners, as Saudi Arabia did in 1991. The unstable environment prohibited handing detention operations over to the Iraqis.[42] Soon after the occupation began, it became apparent that occupation forces were not designed or adequately manned to deal with the complex identification and numbers of captives.[43]

The decision to house prisoners at Abu Ghraib revealed the extent of United States improvisation to handle this problem. It is a violation of Geneva Convention III, Article 22, to house prisoners for any length of time in civil facilities. In addition, the decision highlighted the total lack by U.S. Commanders awareness of the reputation of Abu Ghraib under Hussein’s regime. [44] Among Iraqis, Abu Ghraib was known as the most notorious prison in the country. Hundreds of Iraqi citizens were tortured, executed, and simply disappeared inside the walls of Abu Ghraib.[45]

Located near the population center of Baghdad, Abu Ghraib was under frequent mortar and rocket-propelled grenade attacks. In 2003 and 2004, these attacks killed five U.S. Soldiers and 27 detainees-along with wounding 67 detainees. Establishing an internment facility in an area, which exposes prisoners to hostile fire, is a violation of Geneva Convention III, Article 23.[46]

The treatment of prisoners at Abu Ghraib was called the worst in the nation's history.[47] The senior ranking Democrat on the Foreign Relations Committee, Senator Joe Biden, cited the abuse at Abu Ghraib as "the single most significant blow to United States presence in the Arab world over the past decade."[48] Revelations of U.S. Soldiers abusing prisoners at Abu Ghraib significantly altered the world's view of the legitimacy of U.S. goals in Iraq. Images of this abuse shifted world opinion against the occupation.[49]

The abuse at Abu Ghraib renewed a vigorous discussion of the applicability of the Geneva Conventions III and additional Protocol I to the classification of detainees in U.S. custody. The debate centered on whether, under customary international law, the United States was bound to abide by additional Protocol I, regardless of its ratification status.[50] Interestingly, since the 1956 publication of FM 27-10,"The Law of Land Warfare," customary law has been a part of U.S. law.

> The unwritten or customary law of war is binding upon all nations. It will be strictly observed by United States forces. The customary law of war is part of the law of the United States and, insofar as it is not inconsistent with any treaty to which this country is a party or with a controlling executive or legislative act, is binding upon the United States, citizens of the United States, and other persons serving this country. The customary law of war applies to all cases of declared war or any other armed conflict which may arise between the United States and other nations, even if the state of war is not recognized by one of them. The customary law is also applicable to all cases of occupation of foreign territory by the exercise of armed force, even if the occupation meets with no armed resistance.[51]

In addition to the Geneva Conventions and other international treaties, U.S. Soldiers are bound by this Code of Conduct and are expected to act honorably.

Beyond U.S. obligations under the Geneva Convention in the conflicts in Iraq and Afghanistan, DoD Directive 5100.77 mandates that U.S. forces must comply with the principles of the law of armed conflict, which means all possible, suspected, or alleged

violations of abuse are reportable. However, complying with the law of armed conflict does not mean that every article or Additional Protocol of the Geneva Conventions will apply.[52] Only effective leadership and discipline ensures Soldiers understand the principles of armed conflict and detainees' right s to humane treatment.

> Violations of the principles of the law of armed conflict can result in a breakdown of troop discipline, command control, and force security; subject troops to reciprocal violations on the battlefield or in P.O.W. camps; and cause the defeat of an entire army in a guerrilla or other war through alignment of neutrals on the side of an enemy and hostile public opinion.[53]

The egregious abuses at Abu Ghraib violated principles of armed conflict. They wreaked reprehensible global damage to the U.S. image. Broadly transmitted images of detainee abuse provided fuel for the insurgency and had a deleterious effect on Iraqi public opinion. U.S. violations of principles of armed conflict were painfully evident in widely disseminated photographs depicting the abuse at Abu Ghraib.

Medical Personnel

An investigation of abuse that occurred at Abu Ghraib between October and December 2003 led to charges against 11 U.S. Soldiers who were derelict in their duty by committing aggravated assault and battery against detainees. Although military medical professionals were not directly involved in the actual abuse, investigators reported accusations of medical personnel being complicit by failing to protect detainees' human rights, by collaborating with abusive guards, and by failing to report injuries or deaths caused by abuse.[54]

Army Regulation (AR) 190-8, (1997) Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees, and Field Manual (FM) 3-19.40. Internment/Resettlement Operations (2001) as well as the Geneva Conventions, require

providing detainees with the minimal standards of health, sanitation, security, and human rights. The Schlesinger report cites significant shortfalls in medical personnel training, force structure, and medical equipment. These deficiencies contributed to failure to provide detainees with adequate sanitation, preventive medicine, medical treatment, and health screening.[55] Further, we had no strategy to adequately manage detainee medical care, a situation that became increasingly evident as an unexpected and overwhelming number of detainees arrived at Abu Ghraib.

Until 2004, the U.S. military had no specific theater-level policies for detainee medical care. Lacking guidance, medical personnel were unsure if the standard of care for detainees was the same as that for U.S./Coalition forces in theater.[56] Inspector General Lieutenant General Paul Mikolashek's extensive Department of the Army Inspector General (DAIG) investigation on Abu Ghraib found no inspected unit in compliance with the medical requirements stipulated in AR 190-8. Every medical provider interviewed reported a lack of proper medical equipment to treat older chronically ill detainees.[57] Physicians reported difficulties in transferring detainees requiring a higher echelon because of colleagues' resistance to accept detainee patients.[58] Many medical personnel stated their pre-deployment training for detention operations was inadequate. They admitted that they were unfamiliar with AR 190-8. Regardless of these impediments, medical personnel at the detention facilities claimed they provided the same standard of medical care to detainees as they provided to Coalition Soldiers. [59]

In response to the DAIG and U.S. Medical Command (MEDCOM) investigations, Assistant Surgeon General for Force Projection, Colonel Philip Volpe issued Interim

Guidance on Detainee Medical Care. This document clearly stressed that the "overarching theme of this guidance is that all patients are equal and whenever possible, detainees should receive medical care equal to that of our own troops". Volpe's guidance further directs that health care providers will not involve themselves in interrogation, will not advise interrogators on how to conduct interrogations, and will not provide medical data for the purpose of interrogation or intelligence gathering.[60]

On 6 June 2006 Department of Defense Instruction, 2310.8E superseded the MEDCOM Interim Guidance. This document outlines the basic principles which health care personnel in performance of their duties will observe. It also offers guidance on the management of medical information, on reportable incident requirements, on pre-deployment training, on detainee consent, on standards, and on procedures for Behavioral Science Consultants (BSC) who are working with detainees.[61]

In November 2007, FMI 4.02.46, Healthcare and Detention Operations, published as a Field Manual Interim (FMI), was the first military manual that specifically addresses detainee medical care. It provides detailed and prescriptive guidelines on how to provide a level of health care consistent with U.S. and international standards.

Detainee Health Care

Radically revised detention operations in the aftermath of the Abu Ghraib scandal included establishment of a Combat Support Hospital assigned in theater to provide medical care to detainees. On 1 March 2005, as part of a new U.S. effort to provide health care to detainees, Soldiers from the 67th Combat Support Hospital arrived at Abu Ghraib to establish the first Level III facility for detainees.[62] MG David Quantock, Commander of Task Force 134, Detention Operations in Iraq, commented, "Bringing a

Combat Support Hospital to Abu Ghraib did more to quell the violence and detainee misconduct than any other intervention."[63]

Since 2003, an estimated 160,000 Iraqi citizens passed through U.S. controlled detention. Through family and religious ties, each detainee has significant connections with approximately 100 other Iraq citizens. This means that 16 million of the 26 million Iraqi inhabitants were indirectly affected and influenced by United States custody and control operations.[64] This sphere of influence enhances information operations when detainees receive medical care comparable to that of U.S. forces within the same facility. Promulgation and advertisement of this positive U.S. contribution has tremendous strategic influence; indeed it contributes to the success of other lines of effort in stability operations. Medical care for the host population transcends ideology. As memories of abuse fade, memories of good treatment will be remembered.[65]

Over the past eight years of U.S. involvement in Iraq, medical care provided to detainees evolved with the phases of the operation. During initial combat operations and throughout the surge, surgical and in-patient services were a primary focus. In 2005 the detainee population at Camp Bucca and Camp Cropper included those with missing limbs, severe burns, colostomies and spinal cord injuries and injuries obtained in gun battles.[66]

As U.S. combat troops withdrew from Iraqi cities on 30 June 2009, health care focused increasingly on out-patient care, rather than the former mission of war wound surgery. The Army MEDCOM has exhibited admirable flexibility in its support of theater commanders' staffing requests based on medical conditions and split-base operations. Army MEDCOM performance transcended strict doctrinal compliance with a CSH's

Modified Table of Organization and Equipment (MTO&E). MEDCOM's ability to determine medical staffing requirements based on the actual medical needs of the population positively enhances the capabilities of the health care services offered.

The components of care stipulated in FMI 4.02.46, Medical Support to Detainee Operations, remain unprecedented in scope and detail. The level of detainee health care prescribed in FMI 4.02.46 is not documented anywhere else in the world. At the time of its publication, FMI 4.02.46 was an ambitious theoretical construct, then detainee health care evolved over seven years to reach the recommended standard. This paper describes the standard of health care ultimately achieved. The quality of care reflects the dedication and commitment of hundreds of military health care personnel involved in this mission. The following description of the standard of medical care is based on the author's experience as the commander the 14th CSH (2009-2010).[67]

Standard of Care

The CSH dedicated to detainee health care provides the following services: intensive care, intermediate care, general surgery, orthopedic service, a 24-hour emergency department, primary outpatient care, laboratory, and radiology services. The radiology department services include ultrasound and computed tomography (CAT scan) capabilities. A fully staffed detainee primary care clinic (DPCC) is located within the Theater Internment Facility Rehabilitation Center (TIFRC). Available medical specialties and specialist in the DPCC include Internal Medicine, Family Practice, Emergency Medicine, Surgery, Orthopedics, Cardiology, Optometry, Dental Care,

Nutrition Care, Physical and Occupational Therapy, and a Behavioral Health Team (BHT).

A full range of subspecialties such as Neurology, Nephrology, Urology, Infectious Disease, Cardiology, Dermatology, and Gastroenterology-are available within the theater of operations through various networking capabilities, based on physicians' operational rotations. If it is medically necessary, detainees are transported to the location of the subspecialist for evaluation and treatment. Nurses with training in critical and emergency care staff the Intensive Care Unit (ICU) and Emergency Department (ED). This assures detainees' access to the same set of capabilities provided to the American and coalition forces in the theater of operation.

Detainee contact with medical personnel begins at the Interment Holding Area (IHA) area in the TIFRIC. In this screening area the patients' medical history is recorded and they undergo a physical examination. This detailed initial screening and medical history ascertains detainees' baseline health and identifies medical needs which require immediate attention or chronic conditions for ongoing care, referral to a specialist, or nursing case management.

Behavioral Health Teams (BHT) were deployed as part of the Medical Support to Detainee Operations mission since early in Operation Iraqi Freedom (OIF). The importance of this mission increased exponentially after Abu Ghraib. A BHT consists of highly qualified psychiatrists, psychologists, social workers, psychiatric nurses, and psychiatric health specialists. Caring for detainees' psychiatric needs with dignity and respect affirm legitimacy and encourages others to avail themselves to this service. FMI

04-2.46 charges BHTs to provide detainees with a wide range of services, comparable to those available in theater for the Coalition Force.

An acute care or “sick call” mechanism ensures detainees maintain access to medical providers. Everyday Medics go to the “wire” ensuring detainees receive access to appropriate health care. Detainee sick call is conducted in accordance with the Algorithm-Directed Troop Medical Care (ADTMC) guidelines. These are used by unlicensed providers to evaluate patients. Through the sick call process, medics ensure detainee health care issues are addressed and appropriately triaged to the clinic for evaluation by a medical provider. Because a case manager tracks appointments and medics perform appropriate triage, detainees maintain readily available access to high quality medical care 24 hours a day seven days a week.

Physical Therapy (PT) and Occupational Therapy (OT) are available on an in-patient or out-patient basis. Long standing chronic injuries are common among detainees-these include injuries from gunshot wounds, shrapnel retained from improvised explosive devices (IED), mortar blasts, and improperly aligned fractures. Monthly clinics enable amputees to receive education and training on their prosthetic devices. These clinics are attended by a local Iraqi prosthetists to ensure timely fabrication and repair of prostheses, proper fitting of devices, and appropriate training in care for the device.

The Optometry Clinic provides comprehensive eye examinations and refractive care. The Optometrist provides detainees with eyeglasses, eye medications, and referral for treatment of medical conditions and surgical care at other U.S. military facilities in Iraq.

Eye glasses proved especially important because they enable detainees to read the Koran.

Exhibiting a high rate of periodontal disease because of the lack of dental care prior to interment, detainees frequently require dental services. These services include extractions, fillings, radiological exams, and oral hygiene education. Remedial dental procedures dramatically improved the oral health of Iraqi detainees.

Because of their limited access to comprehensive health care prior to internment, detainees often required medication not authorized for the Coalition force in theater. For example some detainees required insulin, psychotherapeutic medications, and Coumadin. In such cases, the Defense Medical Standardization Board (DMSB) supports tailoring formularies to meet the needs of the detainee health care mission.[68]

Joint Publication 4-02, Health Service Support specifies medical components of stability operations as "activities that establish, enhance, maintain, or influence relations between military forces and host nation, multinational governmental and civilian populace in order to facilitate military operations, achieve United States objectives, and positively impact the health sector."[69] Treating detainees in the same facility with the same standards of care as provided for U.S. and coalition forces provided a very positive message for the nation's information mission. This informational instrument is quantifiable; indeed some families of detainees asked for the continued internment of their relatives to complete their dental and medical treatments.[70]

In addition its contribution to positive strategic communication, health care is an effective Soft Power method for shaping behaviors. Soft Power is getting people to what cooperate by attracting them through shared values, interests and preferences." [71]

Health care is a universally respected and desired commodity. Provision of health care to detainees projects a positive U.S. image and helps to win hearts and minds. It contributes to the effectiveness of other elements of stability operations.[72] The one variation, in providing detainees with care equal to that of coalition forces, is that Soldiers were evacuated out of theater for postoperative care, rehabilitation, and treatment of complicated medical problems.[73]

The ultimate goal of stability operations is the transfer of reconstruction and stabilization activities to a legitimate functioning government.[74] Accordingly the host nation Ministry of Health (MoH) must eventually assume the health care of detainees. This requires a functioning health care system and alignment of current detainee medical operations with the MoH capability without reducing the standard of care. This process begins with understanding Iraq health care capabilities and positively engaging with host-nation health care personnel.

Transfer of Detainee Medical Care

The Ministry of Health (MoH) is responsible for all aspects of the Iraqi health care system. This includes the provision of care, oversight of policy, planning, and operation of health facilities, and the purchase, storage, and distribution of pharmaceuticals, medical supplies, and equipment.[75] The MoH is responsible for delivering the same level of health care to all Iraqi citizens, including prisoners. The successful transition of U.S. detainee health care operations to the MoH depends on a functioning Iraqi heath care system. A historical review of the Iraqi health care system and the effects of war provide insight into the MoH's capability to assume the detainee health care mission

Prior to the first Gulf War and implementation of United Nations sanctions, Iraq possessed one of the strongest health care systems in the Middle East. In the 1970s,

Iraq's oil revenues enabled it to develop a western-style hospital based health care system that provided advanced medical procedures delivered by specialized physicians. Iraq's hospitals remained the best in the Middle East and the pride of the region. Iraqi physicians were fluent in English and trained in Europe and the United States. Hospitals were equipped with cutting-edge medical equipment, technology, and medication.[76]

Iraq's health care system experienced a two-decade decline because of Iraq's war with Iran from 1980-1988, the 1991 Gulf War, and 12 years of United Nations supported multilateral sanctions. During these turbulent times, the ruling Ba'ath party curtailed its investments in the health care system.[77] The health care infrastructure is fundamentally strengthened by proper water treatment, dependable electricity, and proper sanitation. The Gulf War, damaged 85-90 percent of the power grid, water treatment plants operated at 30-60 percent, and only 60 percent of the Iraqi population maintained access to potable water. Approximately 50 percent of sewage treatment plants remained operable and running at 33 to 48 percent capacity, which accounted for 500,000 tons of raw sewage being released daily into the water supply.[78] The ravages of war and the rigors of sanctions greatly degraded Iraqi's healthcare system.

With the escalation in sectarian violence from 2003 to 2007, physicians and health care workers became victims of insurgent violence. It is estimated that 8,000 physicians left the country and an additional 620 medical professionals, including 134 physicians, killed or threatened. The infrastructure was neglected for two decades. Education opportunities for healthcare providers virtually vanished. Medical professionals were fleeing from the violence and corruption. Iraqi's formerly exemplary healthcare system was no longer the pearl of the Middle East.[79]

Many dedicated U.S. medical personnel and interagency players assisted the MoH in reconstructing Iraq's healthcare system. Difficulties with interagency planning and cooperation and lack of a unified strategic medical vision in support of Iraq's nation-building presented many challenges in reestablishing a functional Iraqi health care system.[80] The deteriorating security situation was the most significant challenge to reconstruction efforts.[81]

Despite numerous obstacles and failures of occupying forces and their governments to facilitate the rebuilding of the Iraqi health care system, real progress occurred in 2009. Dr Salih Al- Hasnawi, the Minister of Health (October 2007-December 2011), announced the blueprint for successful reform of the health care system. The Basic Health Service Package (BHSP) established the foundation for a decentralized primary health care (PHC) system. This effort to provide primary health care fulfilled Dr. Al Hasnawi's 2004 vision of an "accessible, affordable, available, safe, and comprehensive quality health service of the highest possible standard that is financially sound and founded on scientific principles in order to meet the present and future health needs of Iraqi people, regardless of their ethnicity, geographic origin, gender or religious affiliation."[82]

Increased collaboration among ministries began with the signing of a memorandum of agreement (MOU) between the Iraqi Ministry of Defense, MoH, and the Kurdistan MoH to implement WorldVista, an integrated, comprehensive health information system. The U.S Department of Veterans Affairs also uses WorldVista. It is currently being implemented in the United Kingdom, Mexico, and Jordan. Iraqi

Healthcare specialists-including physicians, administrators, and information technologists- will train on the system together at the Al Muthana Hospital in Baghdad.[83]

The Strategic Framework Agreement for a Relationship of Friendship and Cooperation between the United States and the Republic of Iraq sets the foundation for a long-term bilateral relationship. Section VI of The U.S.-Iraq Strategic Framework addresses support of Iraq's efforts to strengthen its health systems. This framework trains health and medical staff, maintains dialogue on health policy, encourages international investment in Iraqi health care, facilitates professional exchanges, and fosters relationships with the U.S. Department of Health and Human Services, including the Centers for Disease Control and Prevention.[84] This agreement and a MOA between USAID's Primary Health Care Program and Iraq's MoH forms the foundation for further collaboration to improve and expand the delivery of primary health care throughout Iraq.[85]

It is imperative for the Government of Iraq (GOI) to maintain this momentum to build a health care system that Iraqis find credible and accessible. For many years the Muslim Brotherhood in Egypt and Hezbollah in Lebanon provided medical care that is recognized for higher quality and lower cost compared to the public system. These organizations provide healthcare for all patients regardless of their financial ability, social status, color, gender or faith.[86] A sign on the wall of a Brotherhood hospital affirms the sincerity of their medical mission: "Getting closer to God through medical work."[87] The Muslim Brotherhood and Hezbollah gained considerable political legitimacy among the people because of their social and medical services. Without doubt, social

system reforms impact security and stability-a lesson that the United States and Iraqi leaders should heed.

Conclusion

U.S. military health care personnel are involved at various levels of support throughout all phases of the Iraqi conflict. They served as members of the Coalition Provisional Authority/MoH team, Coalition civil affairs teams, and medical unit personnel with responsibilities in designated areas of operation. They contributed to humanitarian efforts providing primary and trauma health care to the Iraqi populace.[88] Department of Defense Instruction Number 6000.16 directs the MHS to increase its role in establishing, reconstituting, and maintaining health sector capacity and capability for the indigenous population until the host nation is capable of providing these services.[89]

In the NSS, President Obama endorses this development as a strategic, economic, and moral imperative. The United States focuses on assisting people in developing countries to manage security threats, to benefit from global economic expansion, and to establish accountable and democratic institutions that serve basic human needs."[90] Health care is a basic human need. The restoration of this service and its sustainment until indigenous, foreign, or U.S. civilian professionals can assume the task, remains a fundamental MSO responsibility.[91] Improvements in the capacity of the infrastructure and human capital of the Iraqi health care system facilities an exit strategy and a responsible transition of detainee medical care to MoH control.

Nelson Mandela declared, "It is said that no one truly knows a nation until one has been inside the jails. A nation should not be judged by how it treats its highest citizens but its lowest ones."[92] Armed conflict inevitably generates combatants, opportunists, troublemakers, saboteurs, common criminals, former regime officials, and

innocents.[93] Although individuals detained in Iraq are not U.S. citizens, our treatment of these people and their interment environment is judged worldwide. There is no question that U.S. detention operations experienced many difficulties. But we have ultimately emerged from the shadows of Abu Ghraib. Our efforts to rehabilitate Iraqi citizens transformed the U.S.'s image. Major General David Quantock affirms the impact of detainee medical care: "World class medical care really has a positive effect on the detainee population; many negative thoughts about coalition forces were forever altered because of our medical efforts."[94]

Prior to OEF and OIF, the United States attempted to avoid detainee operations and not burden tactical commanders with this daunting task.[95] The vivid illustrations of the abuse and humiliation of detainees at Abu Ghraib will forever be a stain on the honor of the U.S military and a reminder of why detention operations can no longer be an afterthought. There is no doubt that this scandal damaged U.S. national security, fueled the Iraqi insurgency, and undermined efforts to bring peace to Iraq.[96] The lessons learned by the United States on how to hold, question, influence, and release adversaries is an important component of military strategy. Detainee operations must become embedded in doctrine and a part of a unit's Mission Essential Task List (METL) to ensure appropriate individual Soldier training[97].

Medical personnel have a responsibility to ensure the humane treatment of detainees and to protect detainees' physical and mental health.[98] Providing healthcare to detainees with dignity and respect affords an opportunity to influence them, their family members, and their friends.[99] U.S. doctrine affirms the strategic value of winning hearts and minds through the provision of health care, noting its affect on national

security, promotion of U.S. policy, and its use as an informational instrument of power.[100] Health care significantly affected security by helping to win hearts and minds.[101] Military medical personnel responsible for detained personnel must understand that the baseline standard of treatment of detainees is humane treatment in accordance with the law of armed conflict; Geneva Conventions of 1949, including Common Article 3, along with applicable U.S. law and policy.[102]

Most military medical personnel initial exposure to detention operations remains during a deployment. Correctional medical operations are complex; require a wide range of skills, and familiarity with U.S. military, theater, international rules, laws, policies, and procedures. The Academy of Health Science (AHS)-located at the Army Medical Department Center and School (AMEDD C&S) at Fort Sam Houston Texas remains the Army's center for educating medical department personnel. Nearly 35,000 medical professionals from the entire range of AMEDD disciplines (to include Medical, Dental, Army Nurse, Veterinary, Medical Service and Army Specialists Corps) graduate from AHS programs each year.[103] As the Army's premier training institution, the AMEDD C&S should remain the proponent for medical personnel training in detainee health care operations.

At a minimum, curriculum for detainee healthcare should include relevant familiarity with the Geneva Conventions, medical ethics, principles of armed conflict, and medical guidelines for detention operations. Education in detention operations should be included as a module of instruction in all AHS Medical Occupational Specialist (MOS) schools and professional development courses. A three-day course in MSO is offered at the Defense Medical Readiness Training Institute (DMRTI), which

operates under the umbrella of the AHS. The MSO course provides a model for a module of instruction in detainee medical operations.

The minimum requirement for medical personnel deploying in support of detainee medical operations is the completion of two modules of computer based instruction offered at Joint Knowledge Online. Forces Command (FORSCOM) should assist units designated to serve in detention operations in developing and conducting scenario based training that reinforces computer based instruction. This training should incorporate U.S., International, and theater detention operation policies and procedures. Regional Training Site-Medical (RTS-MED) are capable of providing a field environment for scenario-based training.

The 2011 National Military Strategy (NMS) stresses the importance of leaders who can employ a full spectrum of direct and indirect approach–facilitator, enabler, convener, and guarantor.[104] To produce AMEDD leaders capable of acting as facilitators, enablers, conveners, and guarantors, in the complex strategic environment of detention operations, we must provide them with internships, fellowships and assignments in interagency environments such as the State Department Bureau of Conflict and Stabilization Operations and USAID.

Likewise, AMEDD Leaders should have Training With Industry (TWI) opportunities with The National Commission on Correctional Healthcare (NCCHC), a private organization, and The Bureau of Prisons Health Services Division, operated by the Public Health Service. Such opportunities would provide military personnel with expertise in a civilian-centric healthcare correctional model. AMEDD personnel in charge of detainee healthcare in a theater of operation play a key role in the transition of

this critical service to the host nation or other designated authority. Well-trained subject matter experts will facilitate the transition from a military-centric to a civilian-centric model.[105] Health care subject matter experts in detention operations should be assigned to work with the Embassy Health Attaché' and to serve on Multinational Force staffs.

Essentially stability operations provide "time to bring safety and security to the embattled populace; time to provide for the essential, immediate humanitarian needs of the people; time to restore basic public order and a semblance of normalcy to life; time to rebuild the institutions of government and market economy that provide for the enduring peace and stability."[106] In all likelihood, detainee operations will remain a component of future stability operations. The military must institutionalize the skills and knowledge obtained in this nation's provision of detainee health care over the past 10 years. The military can ill-afford to revert to an improvisational prisoner of war policy mentality, given the strategic importance of detainee operations and providing health care as an element of stability operations.

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